POLICY # _____

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

PO Box 4884
Houston, TX 77210-4884

PRESCRIPTION CLAIM FORM

INSTRUCTIONS:

1. Please answer all questions completely
2. Attach the RX (prescription) receipt. It must include the RX name, dosage, patient's name, pharmacy name, date filled, and amount paid.
3. Retain a copy for your records
4. Mail or fax a copy to our Claims Department

Primary Insured's Full Name: _____ Date of birth: ____/____/____

Patient's Full Name: _____ Prescribing Physician: _____

Name of Medication: _____ Amount Paid: _____

Rx #: _____ Treated Condition: _____

Date filled: _____ # of Days Supplied: _____

Prescriptions for Pre-Existing conditions are not reimbursable until after the first 12-months of health coverage. Please contact your agent or our Customer Service department with any questions.

ATTACH PHARMACY RECEIPT BELOW:

Fax: 281-368-7382 Phone: 888-748-3040